

Bob Holden Governor

Division of Professional Registration

Marilyn Taylor Williams, Director

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STATE BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 Missouri Boulevard P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
573-751-3166 FAX
800-735-2966 TDD

website: http://www.ecodev.state.mo.us/pr/healarts

Executive Director

Dear Doctor:

Transmitted herewith are the materials you will need to make application for licensure to practice the healing arts in the State of Missouri. Included in the packet are:

- 1. Application with specific instructions for completing it;
- 2. Postgraduate Reference form (if necessary, please make additional copies);
- 3. Sheet of general information which will help you through the application process;
- 4. Sheet of Documents and Fees you must furnish with your application;
- 5. Verification of Licensure form (if necessary, please make additional copies);
- 6. Verification of Hospital Affiliation form (if necessary, please make additional copies);
- 7. ECFMG Verification form (international medical graduates only);
- 8. National Board of Medical Examiners Request For Endorsement form (national board candidates only);
- 9. FLEX, USMLE and Disciplinary History Request form;
- 10. Authorization For Release of Medical Information and Records.

It is suggested that you read the General Information sheet before beginning the process. Next, read the Medical Practice Act that is located on the Board's website at the address listed above. Besides containing applicant information, this Practice Act governs your professional conduct as a practitioner of the healing arts in the State of Missouri.

There are four (4) ways to become licensed in Missouri: (1) National Board Endorsement (you must apply by this method if you have not taken the FLEX examination, the USMLE or a State Board exam and you are a diplomate of the National Board); (2) Reciprocity with a state license which was obtained by a written examination in that state (FLEX examination, USMLE, LMCC, or State Board examination); (3) Endorsement with the Federation of State Medical Boards/FLEX Examination, USMLE, or LMCC; and (4) Taking the USMLE Step 3 Examination in Missouri.

No application can be considered by the Board until the entire file is complete. **Therefore, you should not make any firm commitment to begin working until you have received notification of licensure in writing from this office.** Proof that a physician has practiced medicine in Missouri before becoming licensed is grounds for denial of licensure.

Please be advised that no application will be processed without a fee. You will be notified in writing, one (1) time if your application is deficient in any way. In addition to the material you are required to submit, the Board makes independent inquiries into your professional background. Therefore, you should allow a minimum of sixty (60) days for the processing of your application once you have filed the completed application and the required documents in this office.

Please be reminded that it is unlawful to misrepresent any material fact, in any way, in connection with application for Missouri licensure. Proof that a physician has misrepresented any material fact is grounds for denial of licensure.

If you have any questions during the process which are not answered in the enclosed material, you may contact the Board of Healing Arts Licensure Section for assistance by dialing 573/751-0098.

Sincerely yours,

LICENSURE DEPARTMENT

GENERAL INFORMATION - ALL APPLICANTS

Please read the following information very carefully. Often the questions applicants have are covered in this document. After reviewing, if you still have questions, please do not hesitate to contact this office.

There are four approved routes to licensure in Missouri: (1) Endorsement from the **National Board**; (2) **Reciprocity** based upon taking and passing the FLEX examination, a state board examination, the USMLE or LMCC examination and upon receiving a license in that State or Territory of the U.S. or the District of Columbia wherein the physician is licensed to practice in the same manner and to the same extent as physicians and surgeons are authorized to practice in Missouri; (3) **Endorsement** from the Federation of State Medical Boards based upon taking the FLEX examination USMLE or the LMCC in another state or territory; or (4) Passing the **USMLE Examination** in Missouri.

All international medical graduates must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and provide evidence of having completed three (3) years of American Medical Association (AMA) approved postgraduate training in **one** (1) recognized specialty area of medicine.

All American medical/osteopathic graduates must present evidence of satisfactory completion of one (1) year of postgraduate training in a program which is approved and accredited to teach post-graduate medical education by the accreditation counsel on graduate medical education of the AMA or the education committee of the AOA.

Applicant must be a graduate of a medical or osteopathic school that has been approved by the Missouri Board.

Missouri does not have direct reciprocity with any state.

The Board does not grant licensure based upon reciprocity with a State Board examination where the Basic Science subjects were not examined.

All candidates for licensure in Missouri must show a proposed Missouri practice address, including the type of practice they will be engaged in (private practice, clinic, hospital, etc.).

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED BY THE BOARD. All required documentation must be received in our office before the file will be considered complete and reviewed.

Please be advised that incomplete applications on file in this office for one (1) year will be **discarded**.

If you have taken a licensing examination more than 3 (three) times, please refer to Chapter 334.040 RSMo before proceeding.

USMLE Steps 1, 2 and 3 must be completed within a seven-year period. The seven-year period begins when you take your first Step, either Step 1 or Step 2. Each Step must be passed within 3 (three) attempts.

Applicants must obtain an examination score of 75 or above, to be eligible for licensure.

Fifth Pathway applicants may satisfy requirements for licensure in Missouri

Licensure fees must be submitted in the form of a bank draft or money order. PERSONAL CHECKS CANNOT BE ACCEPTED. ANY APPLICATION FILED WITHOUT A FEE WILL NOT BE PROCESSED. ALL LICENSURE FEES ARE NON-REFUNDABLE.

A temporary license may be issued for physicians in AMA/AOA approved training programs. Temporary licensure does not provide for the practice of medicine outside the training program. Temporary licenses are not issued for private practice.

Please notice that detailed instructions accompany the document entitled APPLICATION. All items on the application are numbered. Individual instructions for each item may be found following the corresponding number in the document entitled INSTRUCTIONS.

THIS OFFICE DOES NOT ACCEPT FAXED DOCUMENTS.

When your application is received and processed, you will be notified in writing one (1) time of any lacking credentials or other necessary material. Completed applications are reviewed on a weekly basis.

All applications are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein. You may also be requested to appear before the Licensure Committee of the Board.

CLINICAL CLERKSHIPS: In order to determine compliance with Missouri statute 334.031 RSMo, graduates of international medical schools may be required to provide the Board with their clinical clerkship evaluation forms. The Board may also contact the hospitals where the clerkships were performed for additional information. You will be notified on an individual basis if it will be necessary for you to provide the Board with this information.

Allow a minimum of sixty (60) days for the processing of your application once you have filed the completed application fee and the required documents in this office.

The address you have listed on your application as your "current mailing address" will be printed on your certificate.

Once you are issued your permanent Missouri license, you will be required by law to pay a biennial registration fee on or before January 31 of each even numbered year and provide proof of having completed 50 hours of continuing medical education each renewal period.

Effective immediately the Missouri State Board of Healing Arts is accepting information from the Federation Verification Credentials Service for any applicant who wishes to use this service.

INSTRUCTIONS FOR COMPLETING YOUR LICENSURE APPLICATION

The Board wishes to stress that you should provide complete details and dates, complete names, addresses and zip codes as required in your application. Answer all questions. If you do not, the processing of your application may be delayed indefinitely. Allow sixty (60) days for processing your application. Please type or print your application in **BLACK** ink. The following information is provided to assist you in answering the questions.

ITEM #1 – Please indicate by what method you will be applying for licensure. There are four approved methods:

- (1) National Board Endorsement If you have taken all three parts of the National Board exam and have not taken the FLEX exam, USMLE, or a State Board exam, you will need to apply by this method.
- (2) Reciprocity If you have taken the FLEX exam, USMLE, a State Board exam or the LMCC exam, and have a license in the state that the examination was given, you will need to apply by this method.
- (3) FLEX/USMLE or LMCC Endorsement If you have taken the FLEX, USMLE, or LMCC exam and do not have a license to practice medicine in the state that the exam was taken, you will need to apply by this method.
- (4) USMLE-STEP 3 Examination If you are requesting to sit for the USMLE examination in the State of Missouri, you will need to apply by this method.

ITEM #2 - Please print your full name.

ITEM #3 – Please provide address to which all licensure material should be sent.

ITEM #4 - Please indicate Month-Day-Year and place of birth.

ITEM #5 – Indicate home and office telephone numbers and Social Security Number. Please provide a copy of your Social Security Card.

ITEM #6 – (International Medical Graduates Only) Indicate ECFMG number and date it was issued.

ITEM #7 - Please indicate your medical specialty.

ITEM #8 – Indicate the type of practice in which you are currently involved.

ITEM #9 – Indicate intended Missouri practice address. Provide the name of the institution/group, street, city, state and zip. If unknown, please explain.

ITEM #10 – Please indicate the type of practice that you intend to be involved with in the State of Missouri.

ITEM #11 - If your answer is "yes", provide the name of the American Specialty Board(s).

ITEM #12 – If your answer is "yes", indicate whether your status is pending or you are a diplomate. If your answer is no please indicate if you are Board eligible.

ITEM #13 – If your answer is "yes", indicate the number of times each Part and/or Component was taken. (FLEX examinations taken prior to June 1985 would have been given as Part I, Part II and Part III.) List all date(s) and the state(s) in which the exam(s) was given. If you have taken the USMLE, please list the number of times Step 1, Step 2, and Step 3 were taken.

ITEM #14 – If your answer is "yes", indicate the number of times the exam was taken, date(s) and the state(s) in which the exam(s) was given.

ITEM #15 - List all licenses held, whether active or inactive, permanent, temporary, or institutional, date issued and license number.

ITEM #16 – Indicate any other professional licenses that you hold or have held (other than a license to practice medicine or osteopathic medicine) providing the profession and state or country in which the license, certification or registration was held.

ITEM #17 – If your answer is "yes", provide complete details on a separate notarized statement. This should include the States, Provinces, or country, dates and reasons.

ITEM #18 – If your answer is "yes", provide the name, address, dates and reasons on a separate notarized statement.

ITEM #19 – If your answer is "yes", provide complete details, names, addresses, etc., on a separate notarized statement. This should include States, Provinces, or country, dates and reasons.

ITEM #20 – If your answer is "yes", provide complete details, names, addresses, etc., on a separate notarized statement. This should include States, Provinces, or country, dates and reasons.

ITEM #21 – If your answer is "yes", provide complete details on a separate notarized statement.

ITEM #22 – If your answer is "yes", provide complete details on a separate notarized statement. This should include the States, Provinces, or country, dates and reasons.

ITEM #23 – If your answer is "yes", provide complete details on a separate notarized statement. This should include States, Provinces, or country, dates and reasons.

ITEM #24 – If your answer is "yes", provide complete details, dates, etc. on a separate notarized statement. If you have ever been a defendant in any legal action, furnish a **Certified Court Copy** (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case. If the case is still pending, your attorney must also submit a letter stating the current status of the case.

ITEM #25 – If your answer is "yes", provide complete details of the arrest, the dates, places and disposition of the case on a separate notarized statement. Furnish a **Certified Court Copy** (with court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order, or other such documents which reflects the disposition of the matter.

(This does not include any minor traffic or parking violation fines which are under \$100. We suggest that if you have ever had an arrest (no matter how minor), you answer the question "yes" on your application and furnish full details of the incident leading up to and including the arrest and disposition of the case.)

ITEM #26 – If your answer is "yes", provide complete details on a separate notarized statement. Furnish a **Certified Court Copy** (with court seal affixed) of the original complaint, the answer and the disposition of the case. If the case is still pending, please so state. If your insurance company paid a claim without a formal case being filed, then include the dates, names of the patient(s) involved, insurance claim number, insurance carrier, and the facts and circumstances surrounding the claim. It will be necessary for

you to contact the insurance carrier handling the claim and authorize them to submit directly to the Board all information they have on file regarding the claim.

ITEM #27 – If your answer is "yes", provide complete details, dates, etc., on a separate notarized statement. This should include the States, Provinces, or country, dates and reasons.

ITEM #28 – If your answer is "yes", provide complete details and dates, etc., on a separate notarized statement.

ITEM #29 – If your answer is "yes", provide complete details on a separate notarized statement. This should include States, Provinces, or country, dates and reasons.

ITEM #30 – List name of school, city and state, month and year of enrollment and graduation.

ITEM #31 – List name of school, city and state, month and year of beginning and ending time year by year. List degrees and dates received from all colleges attended.

ITEM #32 – List name of school, city and state, beginning date and completion date. If you attended more than one medical school, list each. (If it took you longer than the usual four year period to complete medical school, give full details on a separate notarized statement.)

ITEM #33 – List the name of your medical school of graduation as it appears on your medical diploma. Indicate month, day and year that you graduated from medical/osteopathic school.

ITEM #34 - (Fifth Pathway Candidates Only) List name of

hospital, city, state, dates attended and the name of the Program Director.

ITEM #35 – (Applies to training received in the United States and Canada only.) Indicate the type of training, intern, resident, fellow or other, name of hospital, address, and the department/specialty. Provide the beginning and ending dates. Also indicate the name of the Program Director.

ITEM #36 – List all hospital affiliations within the last 5 years, other than training programs. Provide the name of the hospital, address and dates of affiliations. Attach separate listing if more space is needed.

ITEM #37 – List medical and nonmedical activities since the entrance into medical school to present date. This must be in chronological order and all dates must be accounted for.

ITEM #38 – Our office receives numerous calls from individuals inquiring on the status of a pending application. List who you wish to have access to this information. This section must be completed by all physicians applying for a license.

ITEM #39 – All applicants for medical licensure in Missouri are required to pass the Missouri Medical Jurisprudence Examination.

ITEM #40 – You must sign this oath before a Notary Public. The Notary Public must complete his/her portion and sign, date and seal your signature. You should also attach a recent photograph no larger than $3" \times 5"$ in the space provided. Copies of photographs and magazine clippings are not acceptable.

AMERICAN AND CANADIAN GRADUATES DOCUMENTS AND FEE YOU MUST FURNISH WITH YOUR APPLICATION

 FEES – All licensure fees must be submitted to this office in the form of a MONEY ORDER OR CASHIER'S CHECK payable on or through a United States bank. All fees should be paid to the order of the Missouri Board for the Healing Arts. DO NOT send a personal check or cash. FEES WILL NOT BE REFUNDED.

National Board Endorsement	\$300.00
Reciprocity	\$300.00
USMLE/FLEX/LMCC Endorsement	\$300.00
Licensure via USMLE Step 3 Examination	\$300.00

If you are applying for permanent licensure in the State of Missouri via the USMLE exam, you are required to complete the enclosed permanent licensure application and submit it directly to the Missouri Board of Healing Arts, at the address listed on page 1, with a fee in the form of a cashiers check or money order, in the amount of \$300.00. PERSONAL CHECKS ARE NOT ACCEPTABLE.

- NOTARIZATIONS In order that copies of the documents you furnish with your application will not have to be returned to you to be notarized properly, please have the notarizations done as follows:
 - a. Must be done in the United States or Canada.
 - b. Affidavits and statements should be notarized as "Subscribed and Sworn to" before the Notary Public. The Notary Public must sign it, date it and affix his/her notary seal to the document. Notary seal must show date of expiration.
 - c. Canadian documents may be stamped, dated, and signed by the Commissioner of the appropriate Providence if a Notary Public is not available.
- MEDICAL DIPLOMA Furnish a Copy no larger than 8½" x 11" of your original Professional Diploma (Doctor of Medicine/ Doctor of Osteopathy Diploma).
- 4. **NATIONAL BOARD CANDIDATES** If you are applying for licensure by endorsement from the National Board, please have the National Board forward a certified copy of your scores directly to this office.
- STATE BOARD EXAMINATION If applying for licensure based on an examination given by a State Medical Board, please have the Medical Board forward a certified copy of your scores directly to this office.
- 6. FEDERATION HISTORY REQUEST FORM All applicants who apply for a license in Missouri, regardless of what examination you have taken, are required to complete the enclosed form and submit it to the Federation of State Medical Boards with the appropriate fee. It not only informs us if you have taken the FLEX/USMLE but also if any disciplinary action has been taken against you in any state. DO NOT DISCARD THIS FORM. ALL APPLICANTS MUST SUBMIT IT WITH FEE.
- 7. VERIFICATION OF LICENSURE If you have ever held a

- permanent, temporary or institutional license in any State or territory to practice as a physician, dentist, nurse, physician assistant, speech pathologist or any other profession, the enclosed form must be mailed to each licensing agency in which you are now or have ever been licensed to practice medicine. You may xerox this form for additional copies. It is the applicant's responsibility to supply this form directly to the State Board(s) or territory(s). The State Board(s) or territory(s) must complete our form and return the form directly to this office. However this will be the only form we will accept.
- PHOTOGRAPH Please attach a recent photograph no larger than 3" x 5" in the space provided on the application. (Please do not staple.) Copies of photographs are not acceptable.
- PRE-MEDICAL Furnish a Certified (with school seal affixed) pre-medical transcript of grades from all colleges or universities attended.
- 10. MEDICAL All applicants are required to submit Certified (with school seal affixed) medical/osteopathic transcripts of your grades during professional school. If these credits were obtained from more than one university, you will be required to obtain transcripts from each.
- 11. POSTGRADUATE REFERENCE FORM You will be responsible for mailing Postgraduate Reference Forms to each supervisor or director of your training programs. We are enclosing one (1) form. If more than one reference form is needed, please make additional copies. When the reference forms have been completed by the appropriate individuals, it will be necessary for the forms to be forwarded directly from the training hospital to our office. All postgraduate references must be on our form. We will not accept letters of recommendation. These forms must be sent from ALL training programs.
- 12. NATIONAL PRACTITIONER DATA BANK FORM It will be necessary for you to contact the National Practitioner Data Bank at 1-800-767-6732 or www.npdb.com and advise them that you wish to do a self query. They will provide you with the appropriate documents to perform this self query. When you receive the response from the data bank to your query, please forward all the original information to our office as soon as possible inasmuch as your application will not be considered complete until we receive this information. You may keep a copy for your records. We require the National Practitioner Data Bank response and the Healthcare Integrity Practitioner Data Bank response.
- 13. HOSPITAL AFFILIATION FORM The enclosed form must be submitted to each hospital in which you have been affiliated with in the last five years. The hospital must complete this form, and return it directly to our office. Letters are not acceptable in lieu of this form.

(AMERICAN AND CANADIAN GRADUATES CONTINUED)

- 14. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RECORDS – If you answered yes to any of the questions 21-28, this form must be completed and returned directly to our office.
- 15. NAME CHANGE If your name has changed, you will be required to submit one of the following documents for verification:

Marriage – Furnish a **Copy** no larger than 8 $\frac{1}{2}$ " x 11" of your marriage certificate.

Divorce Decree – Furnish a **Copy** no larger than 8 $\frac{1}{2}$ " x 11" of your divorce decree.

Adoption – Furnish a **Copy** no larger than 8 $\frac{1}{2}$ " x 11" of your adoption order.

Court Order – Furnish a certified court copy of the name change document.

Naturalization – If you have had a name change by naturalization, you will be required to hand carry your original Naturalization Certificate to this office for inspection, since it is unlawful to copy that particular document.

 SOCIAL SECURITY CARD – Furnish a copy of your Social Security Card.

INTERNATIONAL MEDICAL GRADUATES DOCUMENTS AND FEE YOU MUST FURNISH WITH YOUR LICENSURE APPLICATION

 FEES – All licensure fees must be submitted to this office in the form of a MONEY ORDER OR CASHIER'S CHECK payable on or through a United States bank. All fees should be paid to the order of the Missouri Board for the Healing Arts. DO NOT send a personal check or cash. FEES WILL NOT BE REFUNDED.

National Board Endorsement	\$300.00
Reciprocity	\$300.00
USMLE/FLEX/LMCC Endorsement	\$300.00
Licensure via USMLE Step 3 Examination	\$300.00

If you are applying for permanent licensure in the State of Missouri via the USMLE exam, you are also required to complete the enclosed permanent licensure application and submit it directly to the Missouri Board of Healing Arts, at the address listed above, with a fee in the form of a cashiers check or money order, in the amount of \$300.00. PERSONAL CHECKS ARE NOT ACCEPTABLE.

- 2. **NOTARIZATIONS** In order that copies of the documents you furnish with your application will not have to be returned to you to be notarized properly, please have the notarizations done as follows:
 - a. Must be done in the United States or Canada.
 - b. Affidavits and statements should be notarized as "Subscribed and Sworn to" before the Notary Public. The Notary Public must sign it, date it and affix his/her notary seal to the document. Notary seal must show date of expiration.
 - c. The Board will also accept a notarization done in a foreign country if it has "Apostile" stamped on it.
- OFFICIAL TRANSLATIONS If any of your documents, transcripts, etc. are in an international language, this Board requires you to furnish an ORIGINAL, official, word-for-word translation along with a NOTARIZED TRUE COPY of the translation.

AN OFFICIAL TRANSLATION IS:

- 1. One which is done by a government official in the United States.
- One which is done by an official translation service in the United States.
- 3. One which is done by a professor of a language department in a college or university located in the United States.
- 4. One which is done by an Official of the American Embassy in a foreign country. (This document must be translated by the American Embassy not just certified as a true copy and must have the Embassy seal placed on it.)

THE TRANSLATOR MUST:

 Certify that the document is a true translation to the best of his/her knowledge, that he/she is fluent in the language, and is qualified to translate.

- Sign the translation and his/her signature must be certified by a Notary Public.
- 3. Print his/her name and title under the signature.
- 4. Translate on official letterhead.
- PRE-MEDICAL SCHOOL TRANSCRIPTS Furnish a Certified (with school seal affixed) premedical transcripts of grades from all colleges or universities attended.
- MEDICAL SCHOOL TRANSCRIPTS All applicants are required to submit Certified (with school seal affixed) medical transcripts/mark sheets of your grades during professional school. If these credits were obtained from more than one university, you will be required to obtain transcripts from each.
 - SUBMIT ORIGINALS **AND** COPIES OF ALL MEDICAL AND PRE-MEDICAL DOCUMENTS, INCLUDING TRANSLATIONS.
 - ALL ORIGINALS WILL BE RETURNED PER REQUEST AND SUBMISSION OF THE "ORIGINAL DOCUMENTS" FORM.
- 6. **MEDICAL DIPLOMA** Furnish a **Copy** no larger than 8½" x 11" of your original professional diploma.

You may be required to submit your original medical diploma if requested by the Board.

- 7. VERIFICATION FOR LICENSURE IN NATION OF GRADUATION Provide proof of eligibility to practice medicine in the country that you graduated from medical school by furnishing a Copy no larger than 8½" x 11" of the document. (Does not apply to Fifth Pathway Applicants.)
 - IF THE MEDICAL DIPLOMA OR LICENSE TO PRACTICE IN COUNTRY OF GRADUATION ARE IN ANOTHER LANGUAGE THEY MUST BE TRANSLATED (SEE #3). YOU MUST SUBMIT THE ORIGINAL TRANSLATION ALONG WITH A NOTARIZED TRUE COPY OF THE TRANSLATION.
- 8. ECFMG VERIFICATION FORM Complete the enclosed verification form and submit directly to the ECFMG office along with a \$25.00 fee. They must complete and return it directly to our office. Fifth Pathway applicants may submit a notarized "True Copy" of the ECFMG Interim Letter. Canadian graduates are not required to submit an ECFMG Certificate.
- 9. VERIFICATION OF LICENSURE If you have ever held a permanent, temporary or institutional license in any State or territory to practice as a physician, dentist, nurse, physician assistant, speech pathologist or any other profession, the enclosed form must be mailed to each licensing agency in which you are now or have ever been licensed to practice. You may xerox this form for additional copies. It is the applicant's responsibility to supply this form directly to the State Board(s) or territory(s). The State Board(s) or territory(s) must complete our form and return the completed form directly to this office. This will be the only form we will accept.

(INTERNATIONAL MEDICAL GRADUATES CONTINUED)

- 10. POSTGRADUATE REFERENCE FORM You will be responsible for mailing Postgraduate Reference Forms to each supervisor/director of each of your training programs in the U.S. and Canada. You may xerox this form for additional copies. After these forms have been completed by the appropriate training program, they must be forwarded directly from the program to our office. All postgraduate references must be on our form. Letters of recommendation will not be accepted in lieu of this form.
- 11. HOSPITAL AFFILIATION FORM You will be responsible for mailing Hospital Affiliation forms to each hospital that you have been affiliated with in the U.S. or Canada within the past five (5) years. (This does not include your training programs.) You may xerox this form for additional copies. After these forms have been completed by the appropriate hospitals, they must be forwarded directly from the hospital to our office. All hospital affiliations must be completed on our form.
- PHOTOGRAPH Please attach a recent photograph no larger than 3" x 5" in the space provided on the application. (Do not staple.) Copies of photographs are not acceptable.
- 13. FIFTH PATHWAY APPLICANTS Must have the training institution where the Fifth Pathway Program was completed furnish a Postgraduate Reference Form completed by the director of the program, sent directly to our office.
- 14. NAME CHANGE If your name has changed, you will be required to submit one of the following documents for verification:
 - a. Marriage Furnish a Copy no larger than 8 ½" x 11" of your marriage certificate.
 - b. Divorce Decree Furnish a **Copy** no larger than 8 $\frac{1}{2}$ " x 11" of your divorce decree.
 - c. Adoption Furnish a Copy no larger than 8 $\frac{1}{2}$ " x 11" of your adoption order.

- d. Court Order Furnish a certified court copy of the name change document.
- e. Naturalization If you have had a name change by naturalization, you will be required to hand carry your original Naturalization Certificate to this office for inspection, since it is unlawful to copy that particular document.
- 15. NATIONAL PRACTITIONER DATA BANK It will be necessary for you to contact the National Practitioner Data Bank at 1-800-767-6732 or www.npdb.com and advise them that you wish to do a self query. They will provide you with the appropriate documents to perform this self query. When you receive the response from the data bank to your query, please forward all the original information to our office as soon as possible inasmuch as your application will not be considered complete until we receive this information. You may keep a copy for your records. We require the NPDB response and the HIPD response.
- 16. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RECORDS If you answered yes to questions 21 or 28, this form must be completed and returned directly to our office.
- ORIGINAL DOCUMENTS FORM Must be fully completed and enclosed with original documents, to be submitted with application.
- 18. FEDERATION HISTORY REQUEST FORM ALL physicians who apply for licensure in Missouri are required to complete the enclosed Examination and Board Action History Report and mail it to the address specified with the appropriate fee. This is required from ALL physicians whether or not you have taken the examination.
- SOCIAL SECURITY CARD Furnish a copy of your Social Security Card.



APPLICATION FOR MISSOURI LICENSURE - PHYSICIAN

BOARD OF REGISTRATION FOR BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 MISSOURI BLVD., P.O. BOX 4 JEFFERSON CITY, MISSOURI 65102 TELEPHONE (573) 751-0098 FAX (573) 751-3166 TDD #: 800-735-2966

APPLICATION FOR IV	IISSOURI LICENSURE	- PHYSICI	AN		SEE IN	ISTRUCTIO	NS FIRST
1. I HEREBY APPLY FOR A LICEN	NSE AS A PHYSICIAN AND SURGE	ON IN THE STATE	OF MISSOURI ON	N THE BASIS OF:			
NATIONAL BOARD ENDORSEMENT	RECIPROCITY	FLEX/USM ENDORSE		USMLE EXAMINATION COMPUTER-BA	SED TESTING		
2. APPLICANT NAME (LAST, FIRS	ST, MIDDLE, SUFFIX, MAIDEN)						
2 CURRENT MAILING ARRESS	CONTRET OITY STATE ZID						☐ D.O.
3. CURRENT MAILING ADDRESS	(STREET, CITT, STATE, ZIP)						
4. PLACE AND DATE OF BIRTH		5. TELEPHONE					
				HON	1		
0 FOEMO NILIMBED 0 100HE DA	TC	7 MEDIONI OD	FOLALTY.	OFF	ICE -	LIDITY ALLIMANED	
6. ECFMG NUMBER & ISSUE DA	IE	7. MEDICAL SP	ECIALIY		SOCIAL SEC	URITY NUMBER	. *
8. TYPE OF PRACTICE YOU ARE	CURRENTLY INVOLVED IN (CHEC	CK ON)				FEE RECEIVE	D DATE
	RESIDENT	PRIVATE		FACULTY			
			•	TAGGETT			
OTHER (PLEASE EXPLAIN	·						
9. PROPOSED MISSOURI PRACT	TICE ADDRESS (INSTITUTION/GRO	OUP, STREET, CIT	Y, STATE, ZIP) (IF	UNKNOWN, PLEASI	E EXPLAIN)	FOR OFFIC	E USE ONLY
10. TYPE OF PRACTICE THAT YO	OU WILL BE INVOLVED IN IF MISS	OURI LICENSE IS	GRANTED				
□INTERN	RESIDENT	PRIVATE	[FACULTY			
OTHER (PLEASE EXPLAIN	u) >						
•	ANY AMERICAN SPECIALTY BOAF		SE LIST EAGL				
IF NO, ARE YOU BOARD ELIC		RD? IF YES, PLEA	SE LIST EACH			☐ YES☐ YES	□ NO □ NO
·	E PARTS OF THE NATIONAL BOA	RD MEDICAL/OS	TEOPATHIC EXAM	IINATION?		☐ YES	□ NO
STATUS: PENDING	DIPLOMATE						
13. HAVE YOU PREVIOUSLY TAK	CEN THE FLEX EXAMINATION/USM	ILE EXAMINATION	1?			☐ YES	□ NO
IF YES, INDICATE THE NUME PART I/STEP I USMLE	BER OF TIMES YOU HAVE TAKEN I PART II/STEP 2 USMLE	EACH PORTION C		OMPONENT I (FL		COMPONENT	2 (51 57)
PART //STEP TUSINLE	PART II/STEP 2 USWILE	PART III/STEP 3	OSMILE	COMPONENT I (FL	.E.A.)	COMPONENT	2 (FLEX)
LIST DATES AND STATES OF ALI	_ L FLEX EXAMINATIONS/USMLE EX	 Kamination					
14. HAVE YOU PREVIOUSLY TAK	(EN A STATE BOARD EXAMINATIO	N?				☐ YES	□ NO
IF YES, NUMBER OF TIMES							
LIST DATE AND STATES OF ALL	STATE BOARD EXAMINATIONS						
15 List all of the states territ	ories or international countries i	n which you hole	d or have ever h	eld a nermanent t	emporary or i	institutional lice	anse to practice
medicine, in order of attair		in writeri you not	a of flave ever in	cia a permanent, t	cilipolary of t	montanional not	orise to practice
A.	B.	C.		D.		E.	
F.	G.	H.		I.		J.	
16 List all ather profession	and lineanne or contifications	/o.a. Dhyaisis =	Assistant Dee:	intered Names Ch	vironroctor -	to) .vo::	hold or house
•	nal licenses or certifications ense to practice medicine or ost	, ,				, .	
A.			В.				
			D				
C.			D.				

	LEASE ANSWER THE FOLLOWING QUESTIONS WITH THE APPROPRIATE CHECKMARK. IF ANY AR ES, SEE SEPARATE INSTRUCTIONS.	E ANSW	ERED
		YES	NO
17.	Have you, or any license or right to practice held by you, been restricted or disciplined, such disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any U.S. state, territory, federal agency, Canadian province or foreign country?		
18.	Have you had any disciplinary or corrective action taken against you, or had your right to practice restricted, by any professional medical or osteopathic association or society, or by any licensed hospital or medical staff of a hospital?		
19.	Have you surrendered a license issued to you by any U.S. state or any Canadian provincial licensing agency for reasons other than failure to renew?		
20.	Have any charges or complaints been filed against you with the federal government, any federal agency or any U.S. state or Canadian provincial licensing or disciplinary agency?		
21.	Have you been diagnosed or treated for any mental or physical illness or condition that has hindered your ability to practice medicine?		
22.	Have you been denied or surrendered a controlled substance license, registration, certificate or authority issued by the Drug Enforcement Administration (DEA) or any state bureau of narcotics or other agency concerned with controlled substances, or had such license, registration, certificate or authority restricted or disciplined, such disciplinary action to include, but not limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not?		
23.	Has any disciplinary action been taken against you, or has your authority to practice been restricted, by any federal or state agency including, but not limited to, Medicare or Medicaid?		
24.	Have you forfeited collateral for breach or violation of any law, police regulation or ordinance whatsoever, been summoned into court as a defendant, or has any law suit (other than malpractice) been filed against you?		
25.	Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence?		
26.	Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?		
27.	Have you been denied a license to practice medicine or denied the privilege of taking an examination administered by a U.S. state and/or Canadian provincial licensing agency?		
28.	Have you been chemically dependent or treated for chemical dependency in the past five years?		
29.	Have you ever made application for licensure in another state and subsequently withdrawn said application?		

30. HIGH SCH	HOOL NAME						
LOCATION						DATES ATTENDED	
31. PREPROF	ESSIONAL E	DUCATION (LIS	T ALL UNIVERSITIES/C	OLLEGES ATTENDE	D)		
FROM (MO/YR)	TO (MO/YR)		NAME & ADDRESS OF			DEGREE & D	ATE RECEIVED
		CATION (LIST AL	L UNIVERSITIES/COLL			DEODEE 0 D	ATE DECENTED
FROM (MO/YR)	TO (MO/YR)		NAME & ADDRESS OF	- SCHOOL		DEGREE & D	ATE RECEIVED
33 MEDICAL SCH	HOOL OF GRADI	 ATION (PRINT SCHO	OOL NAME AS IT APPEARS ON	VOLIR DIPLOMA)			
OO. WEDIONE OO	TOOL OF CHARLE	Willow (Frank)	OLIVANIE NO II ANI I EARO OR	TOOK DII LOWN)			
LOCATION						DATE OF GRADUATION	DN
FIFTH PATHW	VAY CANDIDA	ATES ONLY					
34. CLINICAL CLE	ERKSHIP (FIFTH	PATHWAY) HOSPITAL	-				
ADDRESS							
PROGRAM DIRECTO	OR					TERM STARTED	COMPLETED
	GREE EXPER	RIENCE (U.S. & C	CANADIAN ONLY)				
A. INTERN		RESIDENT	FELLOW	OTHER (PLEAS	SE EXPLAIN)	>	
NAME OF TRAINING						DEPARTMENT/SPECIALT	Υ
ADDRESS (STREET,	, CITY, STATE, ZIP)						
PROGRAM DIRECTO	OR					TERM STARTED	COMPLETED
B.							
☐ INTERN		RESIDENT	FELLOW	OTHER (PLEAS	SE EXPLAIN)		
NAME OF TRAINING	HOSPITAL					DEPARTMENT/SPECIALT	Y
ADDRESS (STREET,	, CITY, STATE, ZIP)						
PROGRAM DIRECTO	OR					TERM STARTED	COMPLETED

C.	NTERN		RESIDE	FNT	FELLOW	OTHER (PLEASE EXPL	AIN)	
	TRAINING HO	SPITAL					DEPARTMENT/SPECIALT	Y
ADDRESS	S (STREET, CIT	Y, STATE,	ZIP)					
PROGRA	M DIRECTOR						TERM STARTED	COMPLETED
D.			П					
	NTERN TRAINING HO	SPITAL	☐ RESIDE	ENT	FELLOW	OTHER (PLEASE EXPL	DEPARTMENT/SPECIALT	Y
ADDRESS	S (STREET, CIT	Y, STATE,	ZIP)					
PROGRA	M DIRECTOR						TERM STARTED	COMPLETED
36. LIS	ST ALL OF	YOUR	HOSPITAL	_ AFFILIATION:	S (OTHER THAN TR	AINING HOSPITALS) FOR	R THE LAST FIVE YEA	.RS.
						,		PRIVILEGES
		HOS	PITAL		,	ADDRESS	FROM (MO/YR)	TO (MO/YR)
A.								
B.								
C.								
D.								
E.								
37. AC	TIVITIES	STATE	MENT		1			
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		TES		I				
	INNING	EN	IDING			ACTIVITIES		
МО	YEAR	MO	YEAR					

37. AC	TIVITIES	STATE	MENT (CO	NTINUED)				
	DATES							
BEG	INNING	ENDING ACTIVITIES						
MO	YEAR	MO	YEAR					
38. AP	PLICATIO	N INFO	RMATION	RELEASE AUTHORIZATION				
l ha	roby out	horizo	the Sta	te Board of Registration for the Healing Arts, it's Directors or designee to release				
1 116	ı c υy aul	. 101126	uic old	to board of Neglociation for the fleating Arts, it's birectors of designee to release				

and/or discuss information contained in my application for permanent licensure in the State of Missouri to the following individual or organization. (List the name of the individual with whom we may discuss your file with

other than yourself. If name is not listed we will not speak to them about your file.)

NAME OF PERSON(S) TO BE CONTACTED

39. JURISPRUDENCE EXAMINATION

INSTRUCTIONS

Completion of the jurisprudence examination, achieving a score of 75% or higher, is a requirement of the Missouri State Board of Registration for the Healing Arts. Each of the twenty true and false questions is given a weight of five percentage points. All the answers are readily available to you in the text of the Medical Practice Act located on the Board's website at www.ecodev.state.mo.us/pr/healarts.

JURISPRUDENCE EXAMINATION



- 1. T F Missouri law requires all physician applicants to be graduates of a medical or osteopathic college that enforces requirements of a curriculum which contains four terms of thirty-two weeks of actual instruction in each term.
- 2. T F Missouri law permits the granting of a temporary license for private clinic practice.
- 3. T F Chapter 334 requires satisfactory evidence of completion of pre-professional education consisting of a minimum of sixty semester hours of college credits in acceptable subjects leading towards the degree of bachelor of science from an accredited college or university to be eligible for a Missouri license.
- 4. T F Missouri law states that anyone who has been denied a license, permit or certificate to practice in another state shall automatically be denied a license to practice in this state.
- 5. T F Physicians must display their current registration certificate in every office maintained in the State of Missouri.
- 6. T F All physician permanent licenses expire on January 31st of each even numbered year regardless of the date that the license was issued.
- 7. T F Section 334.100 RSMo, provides the grounds for denial, suspension or revocation of a physician's license.
- 8. T F Disciplinary action may be taken against a physician's license for willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests or medical or surgical services.
- 9. T F Persons who report incidents of suspected misconduct to the Board shall not be subject to an action for civil damages.
- 10. T F The Missouri Board of Healing Arts consists of nine members.
- 11. T F The Missouri Board of Healing Arts shall at least quarterly, publish a list of all persons whose licenses have been suspended, revoked, surrendered, restricted, denied or withheld.
- 12. T F Missouri law requires that a physician notify the Board within fifteen days of any address change.
- 13. T F If a physician does not receive a notice to renew his/her registration, he/she is exempt from paying the fee for the next year.
- 14. T F Fees of any kind must be refunded by the Board at the written request of any applicant.
- 15. T F Conviction of a felony offense is not grounds for revocation.
- 16. T F A licensee under this chapter shall, in any letter, business card, advertisement, prescription blank, sign, or public listing or display of any nature whatsoever, designate the degree to which he/she is entitled by reason of his/her diploma.
- 17. T F The Board's rule 4 CSR 150-2.125 states that 75 hours of CME obtained in one year meets the Board's requirement for a three year period.
- 18. T F A physician may require, as a condition of the physician/patient relationship, that the patient only receive drugs dispensed directly from the physician's office.
- 19. T F The Board shall not renew any certificate of registration unless the licensee provides satisfactory evidence that he/she has complied with the Board's minimum requirement for continuing education.
- 20. T F Practicing medicine in Missouri without a current registration is a violation of Missouri law.

40. APPLICANT'S	DATH						
State/Province of	:				County/Parish of		
herein are true; copies of the orig	that all docu ginals have i	ments submitte not been altere	ed with this ed in any f	s application of ashion whatso	r as part of the appl	e of M licatio e origii	, hereby certify under oath that I issouri; that all statements I have made n process that are original or duplicated nal and lawful possessor of and person his application.
	s application						For All Applicants and Instructions that structions and understand that the fee I
to have an invest	igation mad issouri Boar	e as to my mor	al charact	er, profession	al reputation and fitr	ness f	dissouri, I hereby authorize and consent for the practice of medicine, when in the any further information which may be
association, insti furnish to the M complaints filed a	tution, or oth issouri State against me, f any of its ag	ner organization e Board of He formal or inform gents or repres	n having aling Arts al, pendir	control of any and any such ing or closed, o	documents, record formation, including rany other pertinen	ds, an g doc nt data	al, state, federal or international), court, d other information pertaining to me to uments, records regarding charges or a and to permit the Missouri State Board cuments, records, and other information,
	SIGNED IN OF NOTAF	PRESENCE	,	APPLICANT'S SIC	GNATURE		
I hereby certify that t	he below ph	otograph is a ti	rue likene	ss of the perso	on whose signature	appe	ars above.
NOTARY PUBLIC EMBOSSER	SEAL S	TATE				COU	NTY
		UBSCRIBED AND SW DAY C)F	E ME, THIS	YEAR	US	E RUBBER STAMP IN CLEAR AREA BELOW.
	N	OTARY PUBLIC SIGN	ATURE		MY COMMISSION EXPIRES		
	N	OTARY PUBLIC NAME	E (TYPED OR	PRINTED)			
ALL APPLICANTS IN SPACE PROVID		E A PHOTOGR	RAPH				
							PHOTO
EVECUTIVE DIRECTORIO SE	CICION:						
APPROVE	CIOIOIN:		LIC	ENSURE CHA	AIRMAN		
LICENSE NUMBER	DATE ISSUE	D	EXAM TAKEN		DATE OF EXAM		SCORES RECEIVED
MO 419-0394 (1-02)					İ		



STATE BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 MISSOURI BLVD. P.O. BOX 4 JEFFERSON CITY, MISSOURI 65102 (573) 751-0098

901011/1907(12 1121 21(21(02 22) 12))	(676) 761 6666
NAME OF APPLICANT (PLEASE PRINT FULL NAME)	DATE

The physician named above has applied for licensure in the State of Missouri. The Missouri State Board of Registration for the Healing Arts requires a Postgraduate Reference Letter from the program director of each AMA or AOA approved training program the applicant has been in or is currently enrolled in.

Please provide **all** of the information requested on this form and send the form directly to the Missouri State Board of Registration for the Healing Arts, P.O. Box 4, Jefferson City, MO 65102. **This form must be notarized to be acceptable. We will not accept letters of recommendation in lieu of this form. <u>IF ANY PORTION OF THE FORM IS INCOMPLETE IT WILL HOLD UP APPLICANTS FILE AND IT WILL BE RETURNED FOR COMPLETION</u>.**

This information will become part of the permanent records maintained in this office. Please note that the candidate cannot receive final consideration without your cooperation.

final consideration without your cooperation. Please type or print this form in **BLACK** ink. PROGRAM DIRECTOR NAME OF TRAINING HOSPITAL ADDRESS OF TRAINING HOSPITAL AREA IN WHICH YOU ARE BEING CALLED UPON AS A REFERENCE CLINICAL CLERKSHIP (FIFTH PATHWAY) NAME OF DEPARTMENT **INTERNSHIP** RESIDENCY **FELLOWSHIP** DATES APPLICANT WAS IN TRAINING (PLEASE FILL IN THE BLANK) The physician satisfactorily completed ____ __ months of training here. BRIEFLY DESCRIBE THE DUTIES THIS CANDIDATE PERFORMED WHILE UNDER YOUR SUPERVISION AND BRIEFLY DESCRIBE THE NATURE AND TYPE OF SUPERVISION YOU PROVIDED. PLEASE READ THE FOLLOWING AND INDICATE YOUR ANSWER BY A CHECK MARK IN THE APPROPRIATE BOX. (IF ANY ANSWERS ARE "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET.) 1. During the time this physician was in your training program has he/she ever been subject to any disciplinary action, such as imposition of consultation requirements, suspension, or termination or probation? \square Yes \square No 2. At the time the physician left your institution, were any actions instituted, in process or pending against him/her? 3. Has the physician ever shown signs of any behavior, drug, or alcohol problems? \square Yes \square No 4. Has the physician ever shown signs of any mental or physical health problems? ☐ Yes ☐ No

							PAGE 2
INDICATE YOUR EVALUATIO BASED UPON YOUR PERSO						ΓE COLUMN A	T THE RIGHT,
				UNABLE TO EVALUATE	NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE
Basic Medical Knowledge							
Professional Judgment							
Sense of Responsibility							
Clinical Competence							
Technical Skill							
Cooperativeness, Ability to Wo	rk with Other	S					
Medical Record Currency							
Quality of Medical Records							
Patient Management							
Physician-Patient Relationship							
I would rate this applicant's ov		ance under					
my supervision, or based on h	•						
PLEASE READ THE FOLLOWING RECOMM ☐ I recommend this candidate ☐ I recommend this candidate ☐ I do not recommend this candidate	e for licensure	e to practice medicine a	and surgery with	reservatio			
PLEASE LIST THE NAMES AND ADDRESS AND THIS CANDIDATE AND MUST BE NOTARIZED TO BI	DRESSES OF AN THE REASON F	NY OTHER PHYSICIANS ON OR CONTACTING THEM.				PINION, SHOULD	BE CONTACTED
I ATTEST THAT THE FOREGO	DING INFOR		PPLIED IS TRUE	IN EVER			
NAME (PLEASE PRINT OR TYPE)	TITLE	TITLE TELEPHONE NUMBER					
MUST BE SIGNE PRESENCE OF NO		SIGNATURE					
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE	1			COUNTY		
	SUBSCRIBED AN	ID SWORN BEFORE ME, THIS					
		DAY OF	YEAR		USE RUBBER STA	MP IN CLEAR	AREA BELOW.
	NOTARY PUBLIC	SIGNATURE	MY COMMIS EXPIRES	SION			

NOTARY PUBLIC NAME (TYPED OR PRINTED)

VERIFICATION OF LICENSURE FORM

The enclosed verification of licensure form must be completed *on the form provided*.

If the state board will not complete the form provided they must state if you have any "pending complaints" against you. If this information is not provided on the verification form it will delay the processing of your file as we will have to request additional information from the state board.



STATE BOARD OF REGISTRATION FOR THE HEALING ARTS P.O. BOX 4 JEFFERSON CITY, MISSOURI 65102 (573) 751-0098

Please print or type in	BLACK ink.					
I,	NAME OF ADDITIONAL (DISTANCE DOUT)	, hereby	y authorize and reques	t the sta	te	
	I,, hereby authorize and request the state NAME OF APPLICANT (PLEASE PRINT) board of having control of any documents, records and other information					
	rnish to the MISSOURI STATE	,				
	garding charges or complaints		•		J	
other pertinent informa		med against me, formal of mi	iormai, periaing or clos	cu, or a	i i y	
Other pertinent informe	adon.					
SIGNATURE OF APPLICANT		LICENSE NUMBER	ISSUE DATE			
NAME IN FULL (PLEASE PRINT)		DATE OF BIRTH	SOCIAL SECURITY (identification purpo			
				,		
OTHER NAMES USED IN OBTAINING I	LICENSURE	,	1			
CURRENT ADDRESS (street, city, state	and zip code)					
	MUST BE COMPLETED BY AN O	FFICIAL OF THE STATE BOAI	RD AND RETURNED DI	RECTLY	TO THE	
MISSOURI BOARD OF HEALIN	FULL NAME OF LICENSEE					
FOREIGN COUNTRY OF:						
GRADUATE OF		LICENSE NUMBER	ISSUE DATE			
LICENSE METHOD						
NATIONAL BOARD	STATE BOARD EXAM	☐ FLEX EXAMINATION	RECIPROCITY	W/		
OTHER (SPECIFY)	LMCC					
	'ER BEEN NOTIFIED OR REQUI TY IN YOUR STATE? IF YES, ATT		ANY LICENSING OR	YES	NO	
	·					
	EEN THE SUBJECT OF COMPLAI ATE? IF YES, ATTACH DETAILS.		D BY A DISCIPLINARY			
	·					
	ER BEEN WARNED, CENSURED (DRITY IN YOUR STATE? IF YES,		NER BY A LICENSING			
OR BIOON ENVARY ACTIVE	oni i in room office ii res,	ATTAOTT DETAILS.				
4. HAS ANY APPLICATION ATTACH DETAILS.	FOR INITIAL LICENSURE OR	REINSTATEMENT EVER BEE	N DENIED? IF YES,			
ATTAOTT DETAILS.						
COMMENTS, IF ANY						
BOARD SEAL	SIGNATURE AND TITLE			DAT	E	
	>					
	STATE BOARD					



STATE BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 MISSOURI BLVD. P.O. BOX 4 JEFFERSON CITY, MISSOURI 65102 TELEPHONE (573) 751-0098

Please type or print form in **BLACK** ink. NAME OF APPLICANT (LAST, FIRST, MIDDLE) DATE HOSPITAL NAME HOSPITAL ADDRESS (STREET, CITY, STATE & ZIP CODE) DATES PRIVILEGES WERE HELD I hereby authorize the above-named hospital, its staff or representative, to provide to the Missouri State Board of Registration for the Healing Arts any and all information requested below, whether such information is favorable or unfavorable, and I hereby release any and all liability against the above-named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Missouri State Board of Registration for the Healing Arts, P.O. Box 4, Jefferson City, MO 65102. I understand that completed forms returned to me will not be accepted by the Missouri State Board of Registration for the Healing Arts for verification purposes. SIGNATURE SOCIAL SECURITY NUMBER * **HOSPITAL ADMINISTRATOR SECTION** This section must be completed by the hospital administrator or his/her representative and returned to the Missouri State Board of Registration for the Healing Arts. No substitutes will be accepted in lieu of this form. Verifications returned to the applicant will not be accepted. THIS FORM MUST BE NOTARIZED. 1. The above-named physician is/has been affiliated with our hospital _ to . 2. Based on past performance, would you recommend this physician for medical staff reappointment at this ☐ YES ☐ NO hospital? 3. During the stated period of time, were the practice privileges of this individual restricted, limited, suspended, ☐ YES ☐ NO or revoked as a result of disciplinary action? 4. Please submit an explanation if question 2 is answered "no" and/or 3 is answered "ves." COMMENTS, IF ANY I SOLEMNLY SWEAR THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. PRINT FULL NAME OF ADMINISTRATOR/REPRESENTATIVE TITI F SIGNATURE OF HOSPITAL ADMINISTRATOR/REPRESENTATIVE TELEPHONE NUMBER NOTARY PUBLIC EMBOSSER SEAL STATE OF COUNTY SUBSCRIBED AND SWORN BEFORE ME. THIS DAY OF YEAR USE RUBBER STAMP IN CLEAR AREA BELOW. NOTARY PUBLIC SIGNATURE MY COMMISSION NOTARY PUBLIC NAME (TYPED OR PRINTED)



EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

PHILADELPHIA OFFICE
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215-386-5900 • CABLE: EDCOUNCIL, PHA.

REQUEST FOR STATUS REPORT OF ECFMG CERTIFICATION

Reports will be sent directly to STATE MEDICAL BOARDS

PLEASE ATTACH A CHECK FOR \$25 TO THIS REQUEST

Checks should be made payable to ECFMG. Status Reports will be mailed directly to the State Medical Board. Requests without payment attached will not be processed.

To confirm ECFMG certification status for a graduate of foreign medical school, please complete and return this form to:

ECFMG Certification Verification Service PO Box 820424 Philadelphia, PA 19182-0424

Please type or print.

Requests with incomplete or inaccurate information will not be processed.

USMLE/ECFMG IDENTIFICATION NUMBER	
0	
PHYSICIAN'S NAME (FIRST, MIDDLE, LAST NAME/SURNAME/FAMILY NAME)	DATE OF BIRTH
	/////
NAME OF STATE MEDICAL BOARD	DAY MONTH YEAR
Missouri Board of Healing Arts	
STATE BOARD CODE (AS LISTED BY FSMB ON USMLE STEP 3 APPLICATION MATE	RIALS)
0 2 6	
CONTACT NAME	
Pat Castleman	
TITLE	SIGNATURE
Licensure Technician	
TELEPHONE NUMBER (WITH AREA CODE)	
(573) 751-0098	
CHECK/MONEY ORDER (MADE PAYABLE TO ECFMG) ENCLO	SED TO \$25.
ADDRESS TO WHICH STATUS REPORT SHOULD BE SENT: STREET ADDRES	SS
ADDRESS CONTINUED	
CITY STATE	ZIP CODE
NOTE: Requesting organizations must secure and retain the n	physician's signed authorization to obtain certification information.

Physicians who are ECFMG-certified have passed the requisite medical science examination and English language proficiency test and had their medical education credentials verified by ECFMG. ECFMG certification is a prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States; is required by most states for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE Step 3.

Organizations may not resell the ECFMG certification information or make it available to any party beyond this request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided

authorization.

If you have taken any portion of the National Board Examination you will be required to submit the attached form to the National Board office (address is on their form) with the appropriate fee.

If you have any questions concerning this form please contact the National Board office.



NATIONAL BOARD OF MEDICAL EXAMINERS® REQUEST FOR ENDORSEMENT OF NBME CERTIFICATION

IMPORTANT: Please read all instructions before completing this form.

Complete this form ONLY if:

You are a graduate of an LCME-accredited medical school in the U.S. or Canada.

You have passed NBME Parts I, II and III or a combination of NBME Parts and Steps 1, 2 or 3 of the United States Medical Licensing Examination (USMLE)

If you have taken FLEX, all three Steps of USMLE, or need a Step 1 and 2 transcript for your Step 3 application, contact the Federation of State Medical Boards at (817) 868-4000.

Foreign Medical Graduates who need a transcript of NBME or USMLE scores should contact the Educational Commission for Foreign Medical Graduates (ECFMG) at (215) 386-5900.

Osteopathic Physicians who need osteopathic board scores should contact the National Board of Osteopathic Medical Examiners at (312) 635-9955.

The endorsement of certification is provided only to state medical licensing authorities for purposes of licensure and shows your NBME scores **or** your combination of NBME and USMLE scores.

- 1. Complete the form below as directed.
- Enclose the appropriate fee (\$50 in US currency for the first five endorsements and \$5 for each additional endorsement requested at the same time). Make your check or money order payable to the National Board of Medical Examiners Your fee must accompany this form.
- Send the form and fee to: NBME, P.O. Box 48014, Newark, NJ 07101-4814. Send overnight delivery requests to: National Board of Medical Examiners - 48014, c/o Image-Remit, Inc., 205 North Center Drive, Commerce Center - Suite 205, North Brunswick, NJ 08902.

State(s) to Which Endorsement(s)					
Should be Sent					

1			
2			

State(s) to Which Endorsement(s) Should be Sent

3.		
4.		

Total Fee Enclosed:

ALLOW AT LEAST TWO WEEKS FOR PROCESSING.

Requests are processed in the order in which they are received. You will be notified by mail when your endorsement has been sent.

Address and Biographic Information

(Please type or print clearly in uppercase block letters. Use black ink only.)

Provide as much information as possible. If you do not know your Identification Number, do not call the NBME. The other biographic information is sufficient to process your request.

,,	Your Full Name:		
Social Security or Candian Insurance Number	Last		
MO DY YR Date of Birth	First Middle		
Identification (Certificate) Number	Your Address:		
Medical School (Do not use this form if you graduated			
from an osteopathic or foreign medical school)	City	State	Zip Code
Year of Graduation	Signature:		
Previous Name	Date:	Telephone no.:	
	E M-9.		

Contact Information for The National Board of Osteopathic Medical Examiners (NBOME)

National Board of Osteopathic Medical Examiners 8765 W. Higgins Road, Suite 200 Chicago, IL 60631-4101

Phone: (773) 714-0622 Fax: (773) 714-0631 Website: <u>www.nbome.com</u>



National Board of Osteopathic Medical Examiners, Inc.

Level 1/Part I only

Level 2/Part II only

Both Level 1 & 2 Or Part I & II

NBOME

\$15.00 per request per place

\$15.00 per request per place

\$30.00 per request per place

NBOME TRANSCRIPT REQUEST FORM

FAXABLE TO: 773-714-0631

Transcripts are processed in order of date of receipt. Please allow two to three weeks from date of receipt of request for processing. Processing fees are as follows:

0	Complete Transcript (Levels/Parts 1 through 3)	\$40.00 per transcript per place
forwarde	cannot be sent separately. If Level 3 is requed on your behalf.	
Name:		
Current	t Address:	
	one Number:	
	al Board ID# (if known):	
Osteop	pathic Medical School:	
Year G	raduated:	
Addres	s of Destination:	
1		
Credit (Card No. (Visa or Master only):	
	ion Date:	
	ure:	

8765 W. Higgins Road, Suite 200, Chicago, Illinois 60631-4101 (773) 714-0622 Fax (773) 714-0631

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION & RECORDS

PERMANENT LICENSURE DEPARTMENT

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 MISSOURI BOULEVARD P.O. BOX 4 JEFFERSON CITY, MISSOURI 65102 TELEPHONE (573) 751-0098

I hereby authorize any physician, counselor, hospital, clinic, or any other health care provider, medical records librarian, or any person or corporation (including insurance companies) which have records relating to medical, psychiatric, counseling or evaluation received by me, to furnish the Missouri Board of Healing Arts, or its representative, oral or written statements or testimony in any hearing, any and all information with respect to any medical, psychiatric, counseling or evaluation and copies of all hospital, medical, psychiatric, counseling, and evaluation records.

A photocopy of this authorization shall be accepted the same as the original in all instances.

APPLICANT'S NAME (PRINT OR TYPE)	TELEPHONE NUMBER
APPLICANT'S SIGNATURE	DATE
ADDRESS (STREET, CITY, STATE & ZIP CODE)	

IMPORTANT NOTICE

THIS AUTHORIZATION MUST BE NOTARIZED.

NOTARY INFORMATION			
NOTARY PUBLIC EMBOSSER SEAL	STATE OF		COUNTY
	SUBSCRIBED AND SWORN BEFORE ME, THIS		
	DAY OF	YEAR	USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		



ORIGINAL DOCUMENTS - INTERNATIONAL GRADUATES ONLY

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 MISSOURI BLVD. P.O. BOX 4 JEFFERSON CITY, MO 65102 (573) 751-0098

NUMBER OF ORIGINALS RET'D

ments requested by the Board. Please type or print in BLACK ink.				
NAME AS SHOWN ON APPLICATION (LAST, FIRST, MIDDLE)		DATE		
NAME SHOWN ON DOCUMENTS IF DIFFERENT FROM APPLICATION (LAST, FIRST, MIDDLE	:)			
ADDRESS (STREET, CITY, STATE, ZIP) PLEASE NOTIFY BOARD OFFICE OF ANY ADDRESS	CHANGE(S)			
LICT FACIL OPICINAL POCUMENT FNOLOGED	NO. OF	NO OF NOTARIZED COPIES ENCLOSED (
LIST EACH ORIGINAL DOCUMENT ENCLOSED	PAGES	YES	NO	NO. O
LIST ORIGINAL TRANSLATIONS ENCLOSED	NO. OF			
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DATE RETURNED

DATE RECEIVED

STATE OFFICE USE ONLY

NUMBER OF ORIGINALS REC'D

RETURN ADDRESS IF NOT SAME AS LISTED ABOVE

Request for EXAMINATION AND BOARD ACTION HISTORY REPORT (EBAHR) SECTION I - Personal Information PLEASE TYPE OR PRINT CLEARLY Last Name/Surname First and Middle Name Alternate or Previous Name Address FIN USMLE ID Number (City, State, Zip) Phone Date of Birth (Daytime Phone: area code and number) E-mail National Identification Number (NID) (Not applicable if you provided a U.S. Social Security Number) U.S. Social Security Number Country of Citizenship upon entering medical NID Country school Medical School Name, City & Country Female ECFMG Number Graduation Date (Mo/Year) Sex: Male SECTION II - Examination History: If you have recently taken USMLE Steps 1, 2, or 3 and need that score to appear on your EBAHR do not send your request until you have the official results. The Federation DOES NOT hold EBAHR requests for additional examination scores to be released. *Note: FSMB has no access to NBME or FMGEMS scores. (Check all that apply.) Year State Pre-1985 FLEX How many times? When was most recent? FLEX Component 1 How many times? When was most recent? FLEX Component 2 How many times? When was most recent? USMLE Step 1 How many times? When was most recent? USMLE Step 2 How many times? When was most recent? USMLE Step 3 How many times? When was most recent? **SPEX** How many times? When was most recent? **SECTION III - Calculation of Required Payment** (The EBAHR fee is \$50 payable to the Federation of State Medical Boards.) Number of Parties (listed in Section IV, Part B) to which an EBAHR is to be sent. You may request up to two (2) EBAHRs for each \$50 fee. (#EBAHRs/fee) 5-6/\$150, etc. \$ Number of EBAHRs to be sent Express (\$16 per each address). Express does not affect the standard processing time of approximately 5 business days.

Total Payment Required

PLEASE TYPE OR PRINT CLEARLY

ECTION IV - Authorizate. Choose one or more of the following (FSMB cannot provide NBME).	owing examination types to be included on your EBAHR.	X FLEX	X USMLE	SPEX		
	NT YOUR EBAHR/TRANSCRIPT TO BE SE you want the EBAHR to be sent via overnight carrier for					
Express		Express				
	City State Zip (If EBAHRs are to be sent to additional a	ddresses, please attach a cena			<u> </u>	
I hereby authorize and a acknowledge that, in ad disciplinary authority o	the release of examination information indicated in part A of request that the Federation of State Medical Boards of the Undition to my examination scores, the EBAHR will indicate any other credentialing agency. Further, I hereby waive all right	ited States, Inc., provide an Examinative action taken against me and reported s or claims against the Federation for i	on and Board Action H to the Federation's Boa ts provision of the exan	listory Report as described herein ard Action Data Bank by a US/Ca nination history and other information.	n. I understand and anadian licensing and/or	
Notary Stamp/Seal Stamp/Seal Certification of Identification (Certification by a Notary Public is Required.) Name of Notary Public (please print)						
1	Notary Public Signature Date			Commission Ex	xpiration	

D. Each EBAHR notarization requires the following: Notary's Stamp/Seal; Notary's Signature; Notary's Commission Expiration Date; Date of Notarization (MUST BE WITHIN THE LAST SIX (6) MONTHS)

The notary may attach an affidavit, or cover sheet, if he/she chooses. Some states require an affidavit to be used instead of notarizing the actual document. Affidavits must also meet the above requirements and be attached to the EBAHR request form. **Photocopies of the notarization will NOT be accepted.**

Failure to provide sufficient and accurate information and/or failure to sign and properly notarize the authorization may significantly delay your request. Do not send license application or other documentation to this office.

Request for EXAMINATION AND BOARD ACTION HISTORY REPORT (EBAHR)

to provide an EBAHR to you or to a third party. taken against you and reported to the Federation by a licensing or disciplinary board and/or other credentialing agency. you have previously taken the examination(s) designated by you on the attached form. If you have scores on record, the The Federation considers your examination scores to be confidential and, therefore, requires your authorization in order instruction sheet for available examination history. The EBAHR will also include an indication, if applicable, of any action EBAHR will certify a complete history of your scores for the designated examination(s). See the reverse side of this The Federation of State Medical Boards' Examination and Board Action History Report (EBAHR) will certify whether

submitted by you with other documents. NOTE: Licensing authorities generally require that EBAHRs be forwarded directly from the Federation rather than being

GENERAL INSTRUCTIONS FOR REQUESTING AN EBAHR

and no further services from the Federation will be made available until full payment is received. should be made payable to the Federation of State Medical Boards. A \$25 fee will be charged on any returned checks, the standard processing time of approximately 5 business days once received in our office. Checks or money orders party. To have your EBAHR sent by express courier, indicate on the EBAHR request form by checking the Express box and appropriate fee. EBAHRs are sent via first class mail or may be sent via an express courier for an additional \$16 per when designating recipients in Section IV, Part B and by submitting the appropriate fee. Express courier does not affect form. The Federation issues EBAHRs within approximately one week of receiving the completed EBAHR request form fee (e.g. # of EBAHRs/fee: 1-2/\$50, 3-4/\$100, 5-6/\$150, etc.) as indicated in Section IV, Part B of the EBAHR request Attached is an EBAHR request form. The EBAHR fee is \$50. You may designate up to two (2) recipients for each \$50

NOTARIZING THE EBAHR REQUEST FORM

notarization: The EBAHR request form MUST be notarized in Section IV, Part C. Please use the following checklist to ensure proper

- I. Notary's Stamp/Seal
- II. Notary's Name
- III. Notary's Signature
- IV. Notary's Commission Expiration Date
- V. Date of Notarization (must be dated within the last six months)

of notarizing the actual document. Affidavits must also meet the above checklist of requirements and be attached to the The notary may attach an affidavit, or cover sheet, if he/she chooses. Some states require an affidavit to be used instead EBAHR request form. Photocopies of the notarization will NOT be accepted.

MAILING THE EBAHR REQUEST FORM

processing time of approximately 5 business days once received in our office. class mail or express courier. To send it via first class mail, use the Dallas address below. To send it via express courier on your EBAHR, do not send this request until you have received your official score report for that Step. Once the the release of scores at a later date. If you have recently taken USMLE Steps 1,2, or 3 and need that score to appear or overnight delivery service, please use the street address in Bedford. Express courier does not affect the standard All EBAHR requests are processed as they are received. The Federation will not hold an EBAHR request pending EBAHR request form is completed and properly notarized, mail it, along with the appropriate payment, either via first

via first class mail:

FEDERATION OF STATE MEDICAL BOARDS c/o WHOLESALE LOCKBOX

PO Box 970599 Dallas, TX 75397-0599

via express courier or overnight delivery service: FEDERATION OF STATE MEDICAL BOARDS c/o WHOLESALE LOCKBOX

c/o WHOLESALE LOCKBO 1901 Parkwood, #970599 Bedford, TX 76021-5737

Please feel free to contact our office at (817) 868-4041 if you require further assistance.

AVAILABLE EXAMINATION SCORES

The Federation maintains scores for the following examinations:

FLEX — Federation Licensing Examination

SPEX — Special Purpose Examination

USMLE Steps 1, 2 and 3 — United States Medical Licensing Examination

administered the examination to you. The Federation **DOES NOT** maintain or have access to National Board of Medical Examiners (NBME) Parts I, II or III, or the Educational Commission for Foreign Medical Graduates (ECFMG), Foreign Medical Graduates Examination in the Medical Sciences (FMGEMS) Day 1 or Day 2. To obtain scores for these examinations, please contact the entity, which

For information concerning NBME Parts I, II and III administered by the NBME:

National Board of Medical Examiners 3750 Market Street Philadelphia, PA 19104-3190 (215) 590-9500

For information concerning NBME Parts I, II and III administered by ECFMG or for information concerning FMGEMS:

Educational Commission for Foreign Medical Graduates 3624 Market Street

Philadelphia, PA 19104

(215) 386-5900